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CONFIDENTIAL NEUROPSYCHOLOGICAL EVALUATION

Patient Name: Robert Brockman
 Date of Birth (Age): [REDACTED] (78 yr.)
 Date(s) of Evaluation: 12/03/2019
 Evaluation Location: BCM Medical Center, McNair Campus, 9th Floor
 Referred by: James Pool, MD
 Referral Question: Independent Neuropsychological Examination

BACKGROUND AND REFERRAL INFORMATION

Mr. Brockman is a 78 year-old, right-hand dominant, Caucasian male with a two to three-year history of short-term memory loss. The neuropsychological evaluation of his current cognitive, behavioral, and emotional functioning was conducted by request by Kathy Keneally, Partner, Jones Day (New York). The following information was obtained during an interview with Mr. Brockman and his wife, his previous clinical neuropsychological evaluation conducted on 03/01/2019 and limited review of medical records.

Declarations: A forensic evaluation differs from a clinical evaluation in that there is no traditional doctor-patient relationship between the psychologist and the person being evaluated. The purpose of the evaluation is to assist Ms. Keneally in defense for Mr. Brockman's legal tax case; therefore, establishing a treatment relationship would create a potential conflict between the psychologist's role as an objective evaluator versus an advocate for the patient. Consequently, it is important that a retained expert avoid the role of treatment provider. This standard is mandated by the laws of the State of Texas (Texas Administrative Code) as well as the Code of Ethics of the American Psychological Association (2010), and it represents the official position of the National Academy of Neuropsychology (Bush, 2005).

Dr. York was retained for a neuropsychological evaluation by Kathy Keneally of Jones Day. As explained above, she is excluded from providing any direct treatment to Mr. Brockman. Consequently, Dr. York's role was necessarily restricted to that of a forensic consultant rather than a treating doctor in this context. Mr. Brockman was informed of these conditions and consented to the evaluation and to his ability to understand these limitations.

Opinions reached in this report are based on direct interview and results of my neuropsychological evaluation and a review of his provided medical records to clarify the timeline of her medical procedures and hospitalizations. These opinions are based on current neuropsychological assessment techniques and research. Opinions are based upon reasonable neuropsychological probability and are subject to modification based on provision of additional information. The data from this evaluation is contained in Dr. York's confidential files.

Previous Neuropsychological Assessment: Mr. Brockman underwent a clinical neuropsychological evaluation with Dr. York on 03/01/2019. His general intellectual functioning (WAIS-IV FSIQ=87) fell within the low average range, which was a decline from his estimated premorbid intellectual functioning in the above average range. His MoCA was 19/30 (total), 6/6 (orientation), and 2/5 (short-term recall), which was significantly below expectation. Mr. Brockman demonstrated borderline impaired to deficient performances on measures of sustained attention/concentration, learning and recall of prose material and a word list, learning and recall of visual material, semantic fluency, executive functions (set shifting, inhibition, working memory, and problem solving), and visuconstruction. Praxis was impaired for intransitive praxis tasks. These impaired performances were found

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within the low average to average ranges on measures of basic attention, fund of information, verbal and visual abstract reasoning, verbal fluency and naming. This pattern of neuropsychological performance indicated a dementia of mild to moderate severity characterized by deficits in the areas of visuospatial functioning, verbal and nonverbal episodic memory, and executive functioning, with mild functional declines. Self-report of depression was within normal limits (GDS=8). Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 9/31. The NPI-Q (severity=8; distress=11) indicated problems with agitation, anxiety, apathy, irritability, nighttime behaviors, changes in appetite, and depression for an overall minimal level of familial distress, with the exception of his depression and agitation which produced moderate familial distress. He demonstrated movements that were consistent with a parkinsonism disorder. These abnormal movements taken together with his current diagnosis of dementia, and REM Behavior Disorder, his pattern of cognitive impairments was reported as consistent with Dementia with Lewy Bodies (DLB).

Current Concerns and General Condition: Mr. Brockman and his spouse participated in the clinical interview. Mr. Brockman reported that his balance has declined over the past year. He has been using a balance board at the Houstonian but is not making any progress. He denied any falls.

On direct inquiry, he reported that his tax issues are about a small company that he sold to a family trust in 1981. He noted that the government is "mad at him" but "they don't say why," and they want to "confiscate the trust." He said the government is information gathering and talking to people he used to work with. He is concerned that the company will be "ruined" and this will affect the people who work there. He noted that he is starting to think about who will run the company. He reported that he thinks he can continue to be the chairman.

Mrs. Brockman described that her husband's cognition fluctuates on a daily basis from minute to minute. She described that he has "blank times" that he appears more confused. His wife noted that he was having difficulties at work and she had to help him type all of his employee performance reviews. She reported that he has increased initiation problems. He reported that he does not go into the office as much as he did in March 2019. He noted that it takes him longer to process information at work. His wife described that he sits at work for many, but he does not accomplish his tasks described. His short-term memory has continued to decline, and he is repeating himself more often. He is unable to recall details from his daily activities even later in the day. His procedural memory has also declined as he has forgotten how to tie a tie or to use a remote control for their television. She noted that he does not recall the code to unlock his telephone. He has difficulties completing tasks. His wife drives him to the office. She noted that he has declines in his spelling ability particularly while typing. He is unable to multi-task.

Emotional Functioning: Mr. Brockman reported that he began taking Wellbutrin which has improved his mood, but he continues to feel "slightly depressed." He noted that his diagnosis brings him "more down than before." He noted that he has realized that "all of sudden I am old." He denied heightened general anxiety, personality or behavioral changes, suicidal ideation, and auditory hallucinations. Sleep was described as adequate but he is harder to wake up. He is more violently acting out his dreams and has been kicking. He takes trazadone to aid his sleep. He has decreased appetite and has lost 20lbs over the past several months. His wife reported that he began to act out his dreams at least three years ago. He reported that he has floaters in his visual fields. He continued to deny visual hallucinations. It is noted that he had a previous visual illusion described below and a visual hallucination of a bug on the testing room floor that was not present to either the examiner or his wife during his evaluation in March 2019.

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Previous Cognitive Complaints: Mr. Brockman reported declines in his short-term memory over the past 2 to 3 years. He and his wife reported that he is repeating himself, losing possessions, losing his train of thought and is more tangential. He forgets names of new individual and of familiar locations. He also finds it more difficult to complete tasks. His wife noted that he is clumsy getting out of the car and has hit curbs while driving and parking. He has increased difficulties with following directions. His wife noted spelling changes and mild stuttering in his speech. His speech is slowed and he has slowed response latencies. His decision making is also slowed, and he has difficulties multi-tasking.

Medical History: Medical history is remarkable for hypothyroidism, atrial fibrillation, bladder cancer with recurrence, hypercholesterolemia, glaucoma (mild), erectile dysfunction, tremor, micrographia, and back problems. He has plantar fasciitis, which reduces his exercise ability. He reported that he was hospitalized for a prostate infection and pericarditis four years ago. He reported an episode of vision changes in which he saw a bar of color on a spectrum that was moving. He noted he had this visual illusion for 20 minutes and then it went away. He was told that he might have had a visual headache. He began taking levodopa in February 2019. His wife noted a mild motor improvement when he first started on the medication, but when the medication was increased, he had increasing clumsiness. Surgical history is notable for tonsillectomy, cataract surgery, and excision of a melanoma. He reported that when he was in the sixth grade he was hit on the top of the head with a hammer and may have suffered a concussion. He did not lose consciousness. Familial medical history is unremarkable for movement disorders or dementia. Psychiatric history is notable for depression. Mr. Brockman denied current use of tobacco or illicit drugs or a remote history of substance misuse/abuse. He quit drinking alcohol two to three years ago secondary to his atrial fibrillation. He denied a history of seizures, TIA/stroke, or migraines.

Medications: Wellbutrin 100mg tid, trazodone 50mg at night, Synthroid .75mg, Eliquis 2.5mg bid, aspirin, carbidopa/levodopa 25/100mg 2 tablets tid, stool softener, Exelon 2 patches. He noted that he also takes a regimen of vitamins and supplements.

Social History: Mr. Brockman has been married for 50 years, and they have one son. He currently lives with his spouse in their private residence. He earned a BA in Business and attended graduate school for one year in Marketing at The University of Florida. He reported that he was a good student. He is Chairman and CEO of Reynolds and Reynolds Company.

REVIEW OF LIMITED MEDICAL RECORDS

Dr. Joseph Jankovic Evaluation: Mr. Brockman was evaluated by Dr. Joseph Jankovic on March 13, 2019 for his movement disorder. He was diagnosed with postural instability gait disorder subtype (PIGD) of parkinsonism. Dr. Jankovic noted that because Mr. Brockman denied hallucinations and cognitive fluctuations that he does not meet criteria for DLB; however, he acknowledged that he meets criteria for dementia. Mr. Brockman noted that he was worse physically and mentally despite taking levodopa, with a “zombie-like effect” as described by his wife.

Dr. Melissa Yu Evaluation: Mr. Brockman was evaluated by Dr. Melissa Yu on March 20, 2019 for his memory loss. Memory loss was dated to November 2017 in a medical chart note. Dr. Yu medical note stated that a DATSCAN was performed showing significant loss of dopaminergic signal, and he was started on Sinemet and the Exelon patch on 3/13/2019. Anosmia was reported for 10 years. Memory, word finding, and slowed processing speed were reported by his wife and son. His son noted that his father’s cognitive ability fluctuates, with episodes of “blankness” associated with less interaction alternating with improved cognition. His son also noted cognitive fluctuations in his father’s decision making abilities with good and bad days. It was noted that his son has him

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practice clock drawing to test his functioning. Dr. Yu's differential diagnoses included Dementia with Lewy Bodies or Parkinson's Disease Dementia. It was noted that the time course and fluctuations in cognition were more suggestive of DLB.

BEHAVIORAL OBSERVATIONS: Mr. Brockman was tested during a single session as an outpatient. He arrived on time and was accompanied by his spouse who participated in the clinical interview. General appearance was neat and clean. The patient exhibited slowed motor behavior and gait and a mild tremor which was notable on drawings but did not interfere with his performances. He evidenced slowed response latencies. His mood was pleasant, but his affect was flat. Eye movements were normal. Vision (with corrective lenses) and hearing were adequate for the testing session. Conversational speech was coherent but was tangential in conversational speech. There was no evidence of paraphasias. His cognition tended to fluctuate throughout the testing session. He appeared to be confused at times even in the middle of tasks that he originally was completing accurately. He showed mildly decreased ability to follow directions, and he occasionally needed repetition of directions and lost place during set task. He exhibited cooperative test-taking behavior. His attitude towards the examiner was appropriate and friendly. He tended to minimize his cognitive impairments. He passed several embedded and stand-alone measures of performance validity; therefore, the following results are thought to be an accurate estimation of his current cognitive abilities.

MEASURES ADMINISTERED

Montréal Cognitive Assessment (MoCA); Caregiver Neuropsychiatric Inventory (NPI-Q); Clock Drawing Test; Controlled Oral Word Association Test (COWAT version: FAS); General Anxiety Disorder 7-item Scale; Geriatric Depression Scale; Hopkins Verbal Learning Test-Revised (HVLT-R); Neuropsychological Assessment Battery (NAB subtests: Daily Living Memory-Delayed, Daily Living Memory-Immediate, Daily Living Memory-Recognition, Naming, Numbers and Letters, and Visual Discrimination); Praxis Examination; Rey Complex Figure Test-Meyers Version; Semantic Verbal Fluency Test; Stroop Color-Word Interference Test (Stroop subtests: Color, Color-Word, and Word); Trail Making Test (TMT subtest: Trails A); Verbal Series Attention Test (VSAT); Wechsler Adult Intelligence Scale-IV (WAIS-IV subtests: Arithmetic, Coding, Digit Span, Information, Similarities, and Visual Puzzles); Wechsler Memory Scale-4th Edition (WMS-IV subtests: Logical Memory II-Older Adult, Logical Memory I-Older Adult, Logical Memory Recognition-Older Adult, Visual Reproduction I, Visual Reproduction II, and Visual Reproduction Recognition); Wide Range Achievement Test (WRAT-4 subtest: Math Computation); Wisconsin Card Sorting Test (WCST); Instrumental Activities of Daily Living Scale (IADLS); Lawton and Brody Physical Self-Maintenance Scale (PSMS). Clinical Interview with patient and his spouse.

Mr. Brockman did not complete the Trail Making Test (TMT subtest: Trails B) measure as he was unable to comprehend task instructions and maintain task set independently. Informant questionnaires were completed by the patient's spouse.

NEUROPSYCHOLOGICAL FINDINGS

The following clinical descriptors identify performance with the range of Standard Scores (average=100, standard deviation=15) indicated in parentheses: Very Superior (>130), Superior (120-129), High Average (110-119), Average, (90-109), Low Average (80-89), Borderline (70-79), and Deficient (<69). For diagnostic purposes, a cognitive deficit is considered a performance score that is >1.5 standard deviations away from the mean in the direction of poor performance compared to the reference group for that measure (i.e., Z-score) based on peers of similar age, gender, and education background as appropriate. This criterion is equivalent to a Standard Score <78, T-score <35, or a Scaled Score of <5).

Mental Status: Evaluation of Mr. Brockman's general mental status on the MoCA revealed a score of 19/30, which is moderately below expectation. He was fully oriented (6/6). He demonstrated difficulties with set shifting,

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visuospatial construction, sustained attention, repeating one sentence, serial subtractions, and with verbal fluency. He did not recall any words (0/5) and was not aided by category cueing. He was aided by multiple choice cueing for 4/5 words.

Intellectual: Mr. Brockman was administered subtests from a measure of general intellectual functioning (WAIS-IV) and obtained scores ranging from low average to high average yielding a pro-rated Full Scale IQ estimate of 96, which is in the average range.

Attention/Concentration: Attention and mental tracking for overlearned verbal sequences was deficient for speed and for accuracy. Immediate auditory attention span for digits was average with 6 digits forward, 4 digits backward, and 5 digits when re-ordering them in ascending sequence. Speed of single word reading and speed of color naming were deficient. Mental processing speed for manual code transcription was low average. Performance on a simple visual-motor sequencing task requiring scanning and mental tracking was deficient with 0 errors. Written math computation revealed a 5.6 grade equivalent. It is noted that he was unable to perform simple addition, multiplication and division arithmetic problems (e.g., $3 \times 4 = 7$, $14/3$).

Executive: Mr. Brockman's ability to inhibit a dominant verbal response in the face of incongruent visual stimuli was borderline impaired. His abstract verbal reasoning was average. Working memory to perform mental arithmetic was average. Performance on a complex visual-motor sequencing task requiring scanning, tracking, and set-shifting was impaired and the task was discontinued as he was unable to comprehend the task instructions and he was unable to set shift independently. Performance on a novel task of problem-solving and hypothesis testing fell in the low average range (11-16th percentile) with 1 correct category achieved by the end of the task. He made numerous "Other" responses that did not match to any of the 3 possible correct categories. He lost set one time and had to be reminded of the instructions after each card so that he would not match to the wrong set of cards. His performance fluctuated during this task.

Memory: Recall of culturally-based general knowledge was high average. Immediate recall of verbally presented contextual material was average (SS=8). Delayed recall of the stories was low average (SS=7). Retention of initially learned material was 50.0%. Recognition memory was average (16/23). Incremental learning for a semantically-categorized word list across 3 trials was deficient (1, 4, and 4 words per trial), and delayed recall was in the deficient range with 25.0% retention which falls within the deficient range. On recognition memory assessment, 10/12 target words were correctly identified, 3 false positive errors were committed, with discrimination accuracy in the borderline impaired range.

Immediate recall of basic geometric figures was borderline impaired (SS=4). Delayed recall of the designs was deficient (SS=2). Retention of the initially learned material was 0.0%. Recognition memory was average (2/7).

Language: Lexical fluency was borderline impaired with between 5 to 8 words per trial. Semantic fluency was low average with 14 exemplars generated. Confrontation naming of pictured objects was average (NAB Form 1; 29/31). He made an error of transitive limb praxis which was improved with imitation

Visual-Perceptual: His drawing of a complex geometric design scored in the low average range. He demonstrated a mild tremor but it did not interfere with his drawing ability. He maintained the overall gestalt but he distorted or omitted several of the internal details. His spatial reasoning ability to mentally arrange puzzle pieces was low average. Visuoconceptual ability to draw a clock was within normal limits to command (CDT=10/10) and impaired

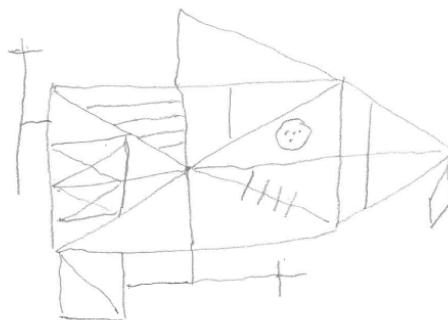
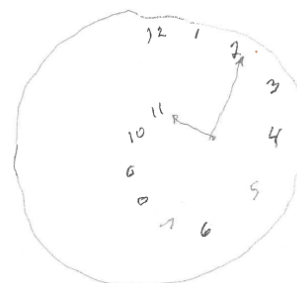
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when copying a model (CDT=8/10). He drew the clock face and began placing the numbers accurately but then the numbers ended in the middle of the clock face. He placed the hands accurately to where he drew the numbers.

Examples of visuospatial performances highlighting Mr. Brockman's fluctuating cognitive functioning.**Rey Complex Figure Test – Copy of a Design****03/01/2019****12/03/2019****Clock Drawing****03/01/2019****12/03/2019**

Mood / Personality: On a self-report measure of anxiety, his responses fell in the minimal range (GAD-7=4/21). On a face valid measure used to assess cognitive, emotional and physical symptoms of depression, Mr. Brockman endorsed the following, suggestive of probable depression (GDS=19): presently unsatisfied with life, terminating activities and/or lack of interest, lack of hope regarding the future, ruminating thoughts, feeling as though something negative is going to occur, unhappiness, helplessness, preferring to stay home, worry about the future, declines in memory, downhearted and blue, lack of excitement for life, difficulty beginning new projects, poor energy, hopelessness, difficulties with concentration, difficulties with decision making, and general declines in thinking skills.

Activities of Daily Living: His spouse served as the informant completing a questionnaire regarding the patient's ability to complete basic and instrumental activities of daily living. Mr. Brockman reportedly has difficulties with self-care ADLs (PSMS=7/30). It was noted that he is constipated and goes to the restroom every half hour; he eats, dresses, grooms, and bathes very slowly. He requires assistance with ambulation. He requires assistance with instrumental activities of daily living (IADLs=14/31) including telephone use, shopping, food preparation,

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transportation, and finances. His wife noted that he seldom uses his phone. He fluctuates in his ability to handle money even with day-to-day expenses. She has to remind him to take his medications, and if she does not then she notices that he has forgotten to take doses.

Neurobehavioral: The patient's spouse completed an inventory assessing for the presence of neurobehavioral symptoms commonly associated with dementia, reportedly observing mild problems with disinhibition and motor disturbance and moderate problems with agitation, depression, apathy, irritability, nighttime behaviors, and changes in appetite (NPI-Q severity=12; distress=25) which produce an overall moderate to extreme level of familial distress.

SUMMARY AND IMPRESSION

Mr. Brockman is a 78 year-old, right-hand dominant, Caucasian male who underwent an independent neuropsychological evaluation as a component of a forensic evaluation. The factual matters stated in this report are, as far as I know, true, and the opinions in the report are genuinely held by me and the report contains reference to all matters I consider significant.

It is this examiner's opinion based on the testing conducted and behavioral observations that Mr. Brockman was putting forth full effort and was not exaggerating or embellishing the nature and extent of his cognitive impairment. It is noted that neuropsychological tests were chosen to best assess Mr. Brockman's cognitive abilities. The testing environment was optimal and the following results are considered a valid estimate of his current neuropsychological and emotional status.

Mr. Brockman currently operates in the average range of general intellectual functioning (WAIS-IV FSIQ=96), which is a significant decline from his estimated premorbid intellectual functioning in the high average range (TOPF=114, from March 2019 evaluation). His MoCA was 19/30 (total), 6/6 (orientation), and 0/5 (short-term recall), which is moderately impaired. Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 14/30, and his wife indicated a significant decline in his functional ability.

Self-report of depression was elevated (GDS=19), but he did not endorse elevated levels of anxiety (GAD-7=4). The NPI-Q completed by his wife (severity=12; distress=25) indicated problems with disinhibition, motor disturbance, agitation, depression, apathy, irritability, nighttime behaviors, and changes in appetite for an overall moderate to extreme level of familial distress.

Mr. Brockman demonstrated borderline impaired to deficient performances on measures of oral and written processing speed, executive functions (including working memory, problem solving, inhibition, set shifting, and verbal fluency), learning and recall of a word list, learning and recall of visual material, and basic visuospatial functioning. His intellectual functioning subtest scores remained within the broadly average range (low average to high average). It is noted that his verbal memory was aided by context with average learning of a story, but he only retained 50% of the material he originally learned after a brief delay (low average). His written arithmetic performance was a 5.6 grade equivalent with difficulties noted in performing basic addition, multiplication and division problems. His basic attention and language (naming and semantic fluency) performances were average.

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Comparison with prior results obtained on 03/01/2019 revealed the following pattern of interim changes:

Declines were found in the areas of:

- Verbal fluency (low average to borderline impaired)
- Graphomotor sequencing (borderline impaired to deficient)
- Learning of a word list (borderline impaired to deficient)
- Decreased functional abilities

Improvements were found in the areas of:

- Sequencing of digits (deficient to average)
- Learning and recall of contextual information (deficient to average and low average with only 50% retention)
- Clock drawing (impairments remain)
- Visuospatial construction of a complex figure

It is noted that Mr. Brockman's cognition fluctuated significantly throughout the evaluation. He demonstrated improvements on a few measures; however, during several tasks, he became more confused and demonstrated a blank stare expression. These fluctuations were more apparent during this evaluation as compared to his previous evaluation in March 2019. Mr. Brockman's pattern of neuropsychological performance indicates a dementia of mild to moderate severity characterized by deficits in the areas of verbal and nonverbal episodic memory, processing speed, executive functioning, and visuospatial functioning with significant functional declines. Mr. Brockman's current cognitive pattern and his parkinsonism, taken together with his dementia at the time of diagnosis of his movement disorder, cognitive fluctuations, and REM Behavior Disorder are consistent with a diagnosis of Dementia with Lewy Bodies (DLB). Visual hallucinations are a hallmark of DLB; however, up to 30% of patients with DLB do not demonstrate visual hallucinations particularly at the early stages of the disorder. Mr. Brockman reported a previous visual illusion and a mild visual hallucination was present during neuropsychological testing in March 2019, which further supports this diagnosis. His dementia falls under the diagnostic category of Lewy Body Dementias.

Based on the current cognitive findings, his diagnosis of dementia, and the breadth and severity of his cognitive impairments and fluctuations, it is my opinion that Mr. Brockman is unable to participate and aid in his own defense. He is unable to recall and demonstrate a thorough understanding of the relevant elements of the issues surrounding the case and manipulate this information in a logical manner that will allow him to make comparisons and weigh his options.



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 Date of Birth (Age): [REDACTED] (79 yr.)
 Date(s) of Evaluation: 10/07/2020
 Evaluation Location: BCM Medical Center, McNair Campus, 9th Floor
 Referred by: James Pool, MD/Kathy Keneally, Jones Day
 Referral Question: Independent Neuropsychological Examination

BACKGROUND AND REFERRAL INFORMATION

Mr. Brockman is a 79 year-old, right-hand dominant, Caucasian male with a three to four-year history of cognitive and behavioral decline. The neuropsychological evaluation of his current cognitive, behavioral, and emotional functioning was conducted by request by Kathy Keneally, Partner, Jones Day (New York) and Dr. James Pool. The following information was obtained during an interview with Mr. Brockman and his son, Robert, his previous clinical neuropsychological evaluation conducted on 03/01/2019 and his previous forensic evaluation conducted on 2019 and limited review of medical records.

Declarations: A forensic evaluation differs from a clinical evaluation in that there is no traditional doctor-patient relationship between the psychologist and the person being evaluated. The purpose of the evaluation is to assist Ms. Keneally in defense for Mr. Brockman's legal tax case; therefore, establishing a treatment relationship would create a potential conflict between the psychologist's role as an objective evaluator versus an advocate for the patient. Consequently, it is important that a retained expert avoid the role of treatment provider. This standard is mandate by the laws of the State of Texas (Texas Administrative code) as well as the Code of Ethics of the American Psychological Association (2010), and it represents the official position of the National Academy of Neuropsychology (Bush, 2005).

Dr. York was retained for a neuropsychological evaluation by Kathy Keneally of Jones Day. As explained above, she is excluded from providing any direct treatment to Mr. Brockman. Consequently, Dr. York's role was necessarily restricted to that of a forensic consultant rather than a treating doctor in this context. Mr. Brockman was informed of these conditions and consented to the evaluation and to his ability to understand these limitations.

Opinions reached in this report are based on direct interview and results of my neuropsychological evaluation including an interview with Mr. Brockman and his son, Robert, and a review of his provided medical records to clarify the timeline of his medical procedures and hospitalizations. These opinions are based on current neuropsychological assessment techniques and research. Opinions are based upon reasonable neuropsychological probability and are subject to modification based on provision of additional information. The data from this evaluation is contained in Dr. York's confidential files.

Previous Neuropsychological Assessments: Mr. Brockman underwent a clinical neuropsychological evaluation with Dr. York on 03/01/2019. In 2019, his general intellectual functioning (WAIS-IV FSIQ=87) fell within the low average range, which was a decline from his estimated premorbid intellectual functioning in the above average range. His MoCA was 19/30 (total), 6/6 (orientation), and 2/5 (short-term recall), which was significantly below expectation. Mr. Brockman demonstrated borderline impaired to deficient performances on measures of

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sustained attention/concentration, learning and recall of prose material and a word list, learning and recall of visual material, semantic fluency, executive functions (set shifting, inhibition, working memory, and problem solving), and visuoconstruction. Praxis was impaired for intransitive praxis tasks. These impaired performances were found within the low average to average ranges on measures of basic attention, fund of information, verbal and visual abstract reasoning, verbal fluency and naming. This pattern of neuropsychological performance indicated a dementia of mild to moderate severity characterized by deficits in the areas of visuospatial functioning, verbal and nonverbal episodic memory, and executive functioning, with mild functional declines. Self-report of depression was within normal limits (GDS=8). Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 9/31. The NPI-Q (severity=8; distress=11) indicated problems with agitation, anxiety, apathy, irritability, nighttime behaviors, changes in appetite, and depression for an overall minimal level of familial distress, with the exception of his depression and agitation which produced moderate familial distress. He demonstrated movements that were consistent with a parkinsonism disorder. These abnormal movements taken together with his current diagnosis of dementia, and REM Behavior Disorder, his pattern of cognitive impairments was reported as consistent with Dementia with Lewy Bodies (DLB).

Mr. Brockman underwent a second neuropsychological evaluation on 12/03/2019. This evaluation revealed average general intellectual functioning (WAIS-IV FSIQ=96), which is a significant decline from his estimated premorbid intellectual functioning in the high average range (TOPF=114, from March 2019 evaluation). His MoCA was 19/30, which is a moderately impaired performance. Mr. Brockman demonstrated borderline impaired to deficient performances on measures of oral and written processing speed, executive functions (including working memory, problem solving, inhibition, set shifting, and verbal fluency), learning and recall of a word list, learning and recall of visual material, and basic visuospatial functioning. His written arithmetic performance was a 5.6 grade equivalent with difficulties noted in performing basic addition, multiplication and division problems. His basic attention and language (naming and semantic fluency) performances were average. Self-care ADLs (PSMS) were 7/30 and instrumental ADLs were 14/30, and his wife indicated a significant decline in his functional ability.

Comparison with prior results obtained on 03/01/2019 revealed declines on measures of verbal fluency (low average to borderline impaired), graphomotor sequencing (borderline impaired to deficient), learning of a word list (borderline impaired to deficient), and decreased functional abilities. He demonstrated improvements in the areas of sequencing of digits (deficient to average), learning and recall of contextual information (deficient to average and low average with only 50% retention), and visuospatial construction of a complex figure, suggesting cognitive fluctuations. Confusion and a blank stare expression was noted during the evaluation.

Self-report of depression was elevated (GDS=19), but he did not endorse elevated levels of anxiety (GAD-7=4). The NPI-Q completed by his wife (severity=12; distress=25) indicated problems with disinhibition, motor disturbance, agitation, depression, apathy, irritability, nighttime behaviors, and changes in appetite for an overall moderate to extreme level of familial distress.

Mr. Brockman's pattern of neuropsychological performance indicated dementia of mild to moderate severity characterized by deficits in the areas of verbal and nonverbal episodic memory, processing speed, executive functioning, and visuospatial functioning with significant functional declines. His dementia taken together with his parkinsonism, cognitive fluctuations, and REM Behavior Disorder remained consistent with a diagnosis of a Lewy Body Dementia (Dementia with Lewy Body or Parkinson's Disease Dementia). Based on his cognitive findings, his diagnosis of dementia, and the breadth and severity of his cognitive impairments and fluctuations, it was opined that Mr. Brockman was unable to participate and aid in his own defense, and he was unable to recall

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and demonstrate a thorough understanding of the relevant elements of the issues surrounding the case and manipulate this information in a logical manner that would allow him to make comparisons and weigh his options.

Current Concerns and General Condition: Mr. Brockman and his son, Robert, participated in the clinical interview. Mr. Brockman reported that his right hand tremor has progressed. He reported overall muscle weakness in his legs and an issue with his rotator cuff from tension and lifting weights. He noted that he discontinued taking his testosterone on his own. He is taking levodopa but he was unsure of his medication regimen as he noted his wife manages his medication box. He noted that he is continuing to use his balance board, but he tends to fall backwards and catch himself. He has not had any actual falls in which he has injured himself.

Mr. Brockman and his son described that his cognition has declined since December 2019 when he was last evaluated. He noted, in particular, his short-term memory and his working memory have declined and his processing speed is slower. He noted declines in his decision making abilities. He repeats himself and asks the same question again without insight. He forgot the passcode to unlock his phone, and he lost his phone. He forgets names of familiar individuals. He is disoriented to month and day of the week, which his family has noted when he is attempting to complete forms. He stopped driving 1 ½ years ago. He has increased word finding difficulties and attempts to google to find the word for which he is searching.

Emotional Functioning: Mr. Brockman reported that his mood is “not good.” He described that business has been difficult and his “morale is not what it used to be.” He is more apathetic. Due to COVID-19, his activities have been limited. He continues to work from home. He noted that the company did not have to lay anyone off and they have transitioned to working remotely. He is continuing to take Wellbutrin which has stabilized his mood. He denied heightened general anxiety, personality or behavioral changes, suicidal ideation, and auditory hallucinations. Sleep was described as adequate but he wakes up more often at 3am and is unable to get back to sleep due to anxiety. He relies on a sleeping aid (trazadone) a couple of times per week. He stated that he was yelling out in his sleep more often. He has decreased appetite with weight loss of 11lbs. He craves ice cream. He denied well-formed visual hallucinations, but he described that he will see things that look like bugs on a shirt, the floor, or a table and wait to see if it moves.

During a telephone call on 11/10/2020, Mr. Brockman’s son, Robbie, described a delusional incident that occurred on 10/17/2020 and 10/18/2020 with his father. Robbie reported that he went to visit his father on Saturday night for a couple of hours. He left the house around 7pm. His father woke up at 5am on Sunday and heard an external door opening and closing and his son’s car driving away. Mr. Brockman went to his office and reported that his computer was on and was unlocked. He stated that the computer was open to pages from the dark web and suicidal information. Mr. Brockman took pictures of the screens, which were actually Yahoo answer pages not related to the dark web or suicide. He was convinced that his son had returned to the house during the night and had broken into his computer. Once he was told otherwise, he thought someone else had entered the house and broken into his computer. The alarm had not been tampered with and there was no one on video entering or exiting the residence during the evening. The family had the computer hard drive analyzed by a third party and did not find any evidence of any tampering or that anyone had visited inappropriate websites. During this time, Mr. Brockman became overly concerned with when he would get his computer back asking numerous times per day.

Previous Cognitive Complaints: Mr. Brockman reported declines in his short-term memory over the past 3 to 4 years. Previously, he and his family reported that he repeats himself, loses possessions, loses his train of thought

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and is tangential. He forgets names of new individuals and of familiar locations. He also finds it more difficult to complete tasks. His wife noted that he is clumsy getting out of the car and hits curbs while driving and parking (He stopped driving 1 ½ year ago). He has increased difficulties with following directions. His wife noted spelling changes and mild stuttering in his speech. His speech is slowed and he has slowed response latencies. His decision making is also slowed, and he has difficulties multi-tasking. Mrs. Brockman described that her husband's cognition fluctuates on a daily basis from minute to minute. She described that he has "blank times" that he appears more confused. His wife noted that he was having difficulties at work and she had to help him type all of his employee performance reviews. She reported that he has increased initiation problems. He noted that it takes him longer to process information at work. His wife described that he sits at work for many, but he does not accomplish his tasks. His short-term memory has continued to decline, and he is repeating himself more often. He is unable to recall details from his daily activities even later in the day. His procedural memory has also declined as he has forgotten how to tie a tie or to use a remote control for their television. She noted that he does not recall the code to unlock his telephone. He is unable to multi-task.

Medical History: Medical history is remarkable for hypothyroidism, atrial fibrillation, bladder cancer with recurrence, hypercholesterolemia, glaucoma (mild), erectile dysfunction, tremor, micrographia, back problems and increased balance problems. He has plantar fasciitis, which reduces his exercise ability. He reported that he was hospitalized for a prostate infection and pericarditis four years ago. He reported an episode of vision changes in which he saw a bar of color on a spectrum that was moving. He noted he had this visual illusion for 20 minutes and then it went away. He was told that he might have had a visual headache. He began taking levodopa in February 2019. His wife noted a mild motor improvement when he first started on the medication, but when the medication was increased, he had increasing clumsiness. Surgical history is notable for tonsillectomy, cataract surgery, and excision of a melanoma. He reported that when he was in the sixth grade he was hit on the top of the head with a hammer and may have suffered a concussion. He did not lose consciousness. Familial medical history is unremarkable for movement disorders or dementia. Psychiatric history is notable for depression. Mr. Brockman denied current use of tobacco or illicit drugs or a remote history of substance misuse/abuse. He quit drinking alcohol two to three years ago secondary to his atrial fibrillation. He denied a history of seizures, TIA/stroke, or migraines.

Dr. Joseph Jankovic Evaluation: Mr. Brockman was evaluated by Dr. Joseph Jankovic on March 13, 2019 for his movement disorder. He was diagnosed with postural instability gait disorder subtype (PIGD) of parkinsonism. Dr. Jankovic noted that because Mr. Brockman denied hallucinations and cognitive fluctuations that he does not meet criteria for DLB; however, he acknowledged that he meets criteria for dementia. Mr. Brockman noted that he was worse physically and mentally despite taking levodopa, with a "zombie-like effect" as described by his wife.

Dr. Melissa Yu Evaluation: Mr. Brockman was evaluated by Dr. Melissa Yu on March 20, 2019 for his memory loss. Memory loss was dated to November 2017 in a medical chart note. Dr. Yu medical note stated that a DATSCAN was performed showing significant loss of dopaminergic signal, and he was started on Sinemet and the Exelon patch on 3/13/2019. Anosmia was reported for 10 years. Memory, word finding, and slowed processing speed were reported by his wife and son. His son noted that his father's cognitive ability fluctuates, with episodes of "blankness" associated with less interaction alternating with improved cognition. His son also noted cognitive fluctuations in his father's decision making abilities with good and bad days. It was noted that his son has him practice clock drawing to test his functioning. Dr. Yu's differential diagnoses included Dementia with Lewy Bodies or Parkinson's Disease Dementia. It was noted that the time course and fluctuations in cognition were more suggestive of Dementia with Lewy Bodies.

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Medications: Wellbutrin 100mg tid, trazodone 50mg at night, Synthroid .75mg, Eliquis 2.5mg bid, aspirin, carbidopa/levodopa25/100mg 2 tablets tid, stool softener, Exelon 2 patches. He noted that he also takes a regimen of vitamins and supplements.

Social History: Mr. Brockman has been married for over 50 years, and they have one son, who is reported to have a diagnosis of an Autism Spectrum Disorder. He currently lives with his spouse in their private residence. He earned a BA in Business and attended graduate school for one year in Marketing at The University of Florida. He reported that he was a good student. He is Chairman and CEO of Reynolds and Reynolds Company.

Behavioral Observations: Mr. Brockman was tested during a single session as an outpatient. He arrived on time and was accompanied by his son who participated in the clinical interview. General appearance was neat and clean. He exhibited slowed, unsteady gait and slowed motor behavior. He evidenced a mild tremor which was notable on drawings but did not interfere with his performances. His mood was pleasant, and affect was appropriate but somewhat flat. Eye movements were unremarkable. Vision (with corrective lenses) and hearing were adequate for the testing session. His cognition fluctuated throughout the testing session. He appeared to be confused at times even in the middle of tasks that he originally was completing accurately. Conversational speech was coherent, but at times he appeared confused, particularly with following directions, and he was tangential without insight. There was no evidence of paraphasias. He showed moderately decreased ability to follow directions, and he often needed repetition of directions due to confusion. He lost place frequently during set task. He exhibited cooperative test-taking behavior, and his attitude towards the examiner was appropriate and friendly. He lacked insight into the severity of his cognitive impairments. The following results are thought to be an accurate estimation of his current cognitive abilities. He passed embedded measures of performance validity; therefore, the following results are thought to be an accurate estimation of his current cognitive abilities.

MEASURES ADMINISTERED

Montréal Cognitive Assessment (MoCA); Clock Drawing Test; Controlled Oral Word Association Test (COWAT version: FAS); General Anxiety Disorder 7-item Scale; Geriatric Depression Scale; Hopkins Verbal Learning Test-Revised (HVLTR); Neuropsychological Assessment Battery (NAB subtest: Naming); Praxis Examination; Rey Complex Figure Test-Meyers Version; Semantic Verbal Fluency Test (SVF version: Animals); Stroop Color-Word Interference Test (Stroop subtests: Color, Color-Word, and Word); Trail Making Test (TMT subtest: Trails A); Verbal Series Attention Test (VSAT); Wechsler Adult Intelligence Scale-IV (WAIS-IV subtests: Coding, Digit Span, Information, Similarities, and Visual Puzzles); Wechsler Memory Scale-4th Edition (WMS-IV subtests: Logical Memory II-Older Adult, Logical Memory I-Older Adult, Logical Memory Recognition-Older Adult, Visual Reproduction I, Visual Reproduction II, and Visual Reproduction Recognition). Clinical Interview with patient and his son. Mr. Brockman did not complete the Trail Making Test (TMT subtest: Trails B) measure due to cognitive/behavioral problems.

NEUROPSYCHOLOGICAL FINDINGS

The following clinical descriptors identify performance with the range of Standard Scores (average=100, standard deviation=15) indicated in parentheses: Very Superior (>130), Superior (120-129), High Average (110-119), Average, (90-109), Low Average (80-89), Borderline (70-79), and Deficient (<69). For diagnostic purposes, a cognitive deficit is considered a performance score that is >1.5 standard deviations away from the mean in the direction of poor performance compared to the reference group for that measure (i.e., Z-score) based on peers of similar age, gender, and education background as appropriate. This criterion is equivalent to a Standard Score <78, T-score <35, or a Scaled Score of <5).

Mental Status: Evaluation of Mr. Brockman's general mental status on the MoCA revealed a score of 19/30, which is below expectation. He was incompletely oriented (5/6, missing the date) and short-term recall was 0/5. He

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was aided by category cueing for one word and multiple choice cueing for 3 words. He demonstrated difficulties with set shifting, drawing a cube, and placing the hands on a clock face. These three tasks took him 15 minutes to complete, and he attempted the drawing of the cube twice unsuccessfully. He named 2/3 pictured animals. He also had difficulties with serial subtractions and verbal fluency.

Intellectual: Mr. Brockman was administered subtests from a measure of general intellectual functioning (WAIS-IV) and obtained scores ranging from extremely low to average yielding a pro-rated Full Scale IQ estimate of 80 which is in the low average range.

Attention / Concentration: Attention and mental tracking for overlearned verbal sequences was deficient for speed and for accuracy. Immediate auditory attention span for digits was borderline with 5 digits forward, 3 digits backward, and 3 digits when re-ordering them in ascending sequence. Speed of single word reading and speed of color naming were deficient. Mental processing speed for manual code transcription was extremely low. Performance on a simple visual-motor sequencing task requiring scanning and mental tracking was deficient with 1 error.

Executive: Mr. Brockman's ability to inhibit a dominant verbal response in the face of incongruent visual stimuli was deficient. His abstract verbal reasoning was average. Performance on a complex visual-motor sequencing task requiring scanning, tracking, and set-shifting was impaired and the task was discontinued.

Memory: Recall of culturally-based general knowledge was average. Immediate recall of verbally presented contextual material was borderline impaired (SS=5). Delayed recall of the stories was borderline impaired (SS=4). Retention of initially learned material was 33.3%. Recognition memory was high average (20/23). Incremental learning for a semantically-categorized word list across 3 trials was deficient (3, 3, and 6 words per trial), and delayed recall was in the deficient range with 0.0% retention which falls within the deficient range. On recognition memory assessment, 9/12 target words were correctly identified, 5 false positive errors were committed, with discrimination accuracy in the deficient range.

Immediate recall of basic geometric figures was borderline impaired (SS=5). Delayed recall of the designs was deficient (SS=2). Retention of the initially learned material was 0.0%. Recognition memory was borderline impaired (1/7).

Language: Lexical fluency was low average with between 8 to 12 words generated per trial. Semantic fluency was deficient with 9 exemplars generated. Confrontation naming of pictured objects was high average (NAB Form 1; 30/31).

Visual-Perceptual: His drawing of a complex geometric design scored in the deficient range. Time required to copy design was borderline impaired. After 5 minutes of attempting to copy this design, the gestalt was not present, and he reported that he was unable to perform this task. His spatial reasoning ability to mentally arrange puzzle pieces was low average. Visuoconceptual ability to draw a clock was impaired to command (CDT=6/10) and impaired when copying a model (CDT=7/10). On command clock on the MoCA, he drew the hands to the 10 and the 11 for "10 after 11," and he attempted to place the hands first prior to writing in the numbers. When later asked to draw a clock, he drew a clock face and the numbers 12, 3 and 5, with 13 tic marks and two hands pointing to the second and third tic mark for "10 after 11." When asked to copy a clock, he omitted the number 10 and wrote the numbers 12-7 in the right half of the clock. He did not maintain the hand size differentiation.

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Motor Functioning: Mr. Brockman is right-hand dominant. On formal examination, buccofacial, transitive, and intransitive classes of praxis were intact.

Mood / Personality: On a self-report measure of anxiety, his responses fell in the mild range (GAD-7=5/21). On a face valid measure used to assess cognitive, emotional and physical symptoms of depression, Mr. Brockman endorsed the following, suggestive of probable depression (GDS=20): presently unsatisfied with life, terminating activities and/or lack of interest, boredom, lack of hope regarding the future, generally poor spirit/mood, feeling as though something negative is going to occur, unhappiness, helplessness, preferring to stay home, worry about the future, declines in memory, downhearted and blue, worthlessness, lack of excitement for life, difficulty beginning new projects, poor energy, difficulties with concentration, lack of enjoyment first thing in the morning, and general declines in thinking skills.

SUMMARY AND IMPRESSION

Mr. Brockman is a 78 year-old, right-hand dominant, Caucasian male who underwent an independent neuropsychological evaluation as a component of a forensic evaluation. The factual matters stated in this report are, as far as I know, true, and the opinions in the report are genuinely held by me and the report contains reference to all matters I consider significant.

It is this examiner's opinion based on the testing conducted and behavioral observations that Mr. Brockman was putting forth full effort and was not exaggerating or embellishing the nature and extent of his cognitive impairment. It is noted that neuropsychological tests were chosen to best assess Mr. Brockman's cognitive abilities. The testing environment was optimal and the following results are considered a valid estimate of his current neuropsychological and emotional status.

Mr. Brockman currently operates in the low average range of general intellectual functioning (WAIS-IV FSIQ=80), which is a significant decline from his estimated premorbid intellectual functioning in the high average range (TOPF=114, from March 2019 evaluation). His MoCA was 19/30 (total), 5/6 (orientation), and 0/5 (short-term recall), which is moderately impaired. Self-report of depression was elevated (GDS=20), and anxiety was mildly elevated (GAD-7=5).

Mr. Brockman demonstrated borderline impaired to deficient performances on measures of basic attention, oral and written processing speed, executive functions (including working memory, problem solving, inhibition, and set shifting), learning and recall of prose material and a word list, learning and recall of visual material, and basic and complex visuospatial functioning. His intellectual functioning subtest scores declined from his last evaluation ranging from the deficient to the average range. He continues to demonstrate average scores on fund of information, naming, verbal fluency, and verbal and visual reasoning.

Comparison with prior results obtained on 12/03/2019 revealed the following pattern of interim changes:

Declines were found in the areas of:

- Intellectual functioning (Full Scale Index: average to low average)
- Semantic fluency (low average to deficient)
- Inhibition (borderline impaired to deficient)
- Graphomotor sequencing (further in deficient range)

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- Basic attention (forward and backward: average to low average; sequencing: average to borderline impaired)
- Learning of prose material (average to borderline impaired)
- Delayed recall of prose material (low average to borderline impaired)
- Visuospatial construction (Clock drawing and Rey-O)

No interim Improvements were found as compared to his performance on 12/03/2019.

Mr. Brockman's current cognitive functioning was impaired across all domains assessed, with significant interim declines noted from his evaluation in March 2019. He continued to demonstrate significant cognitive fluctuations throughout the evaluation with confusion and impaired abilities to follow instructions. Mr. Brockman's pattern of neuropsychological performance continues to indicate a dementia of mild to moderate severity characterized by deficits in the areas of verbal and nonverbal episodic memory, processing speed, executive functioning, and visuospatial functioning with significant functional declines. Mr. Brockman denies experiencing well-formed visual hallucinations; however, he has experienced visual illusions, brief visual hallucinations, and a recent delusional episode. His current cognitive pattern and his parkinsonism, taken together with his dementia at the time of diagnosis of his movement disorder, cognitive fluctuations, and REM Behavior Disorder continue to suggest Dementia with Lewy Bodies. His cognitive profile demonstrated interim cognitive declines across all domains assessed.

Based on the current cognitive findings, his diagnosis of dementia, and the breadth and severity of his cognitive impairments and fluctuations, it remains my opinion that Mr. Brockman is unable to participate and aid in his own defense. Due to the neurodegenerative nature of this disease and the lack of effective treatments, his prognosis is for continued cognitive decline. He is unable to recall and demonstrate a thorough understanding of the relevant elements of the issues surrounding the case and manipulate this information in a logical manner that will allow him to make comparisons and weigh his options.

It is this examiner's opinion based on record review, behavioral observations, patient interview, and current and previous neuropsychological assessments.



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